



Farmington Municipal Schools Health Services Student Health Questionnaire

Student Health Information for School Year 2023-2024

Please complete the form to provide accurate and up-to-date health information for your student for the purpose of routine or emergency care and communications between the school, home, and emergency medical services as needed. Please inform the School Nurse if any information changes during the school year.

Last Name: _____ First Name: _____ Middle: _____

Student ID#: _____ Grade: _____ Sex: _____ Date of Birth: _____

Has your child ever received Special Education Services (IEP): ☐ Yes ☐ No **OR** Section 504 Plan: ☐ Yes ☐ No

Student's Medical Provider Name: _____ Phone Number: _____

Emergency and Prescription Medications

Does your student need emergency or prescription medications during school or school activities? (Examples: asthma inhaler, epinephrine auto-injector, seizure medications, migraine medications, diabetes medications, or other)

☐ Yes ☐ No NAME OF MEDICATION(S): _____

Does your student take any prescribed medication(s)? ☐ Yes ☐ No

Do they take prescribed medication: ☐ At Home ☐ At School ☐ At Home AND School

NAME and DOSAGES OF PRESCRIBED MEDICATION(s): _____

*Is there any other information you wish to add about your student? _____

Student Nutrition

If your student requires any special dietary accommodations, you must contact your School Nurse. Additional paperwork may be required.

Food sensitivities: _____

Food allergies: _____

- ☐ I opt-in and give permission for my student's allergen information to be shared with the FMS Student Nutrition Team
☐ I opt-out and do not give permission to share my student's allergen information with the FMS Student Nutrition Team

Health History

List all allergies and/or sensitivities:

Medication allergies: _____ Insect Allergies requiring medication: _____

Environmental allergies: _____ Other: _____

Check any of the following applicable medical conditions diagnosed by a medical provider (past or present).

****Some items may not be applicable to your student.**

- | | |
|--|---|
| ☐ ADD/ADHD | ☐ Glasses or contacts |
| ☐ Anaphylactic allergy | ☐ Head trauma |
| ☐ Asthma | ☐ Concussions - How many? _____ |
| ☐ Inhaler needed for school? | ☐ Hearing loss ☐ Hearing aids |
| ☐ Blood or bleeding disorder | ☐ Heart problem: _____ |
| ☐ Bone or orthopedic | ☐ Hospitalizations for injury, surgery, illness |
| ☐ Braces, retainer, or orthodontic appliances | ☐ Mental health/psychiatric disorders |
| ☐ Cancer or history of cancer | ☐ Migraine headaches |
| ☐ Depression | ☐ Pregnant or parenting student |
| ☐ Diabetes: ☐ Type 1 ☐ Type 2 | ☐ Seizures |
| ☐ Ear infections or tubes | ☐ Substance Abuse |
| ☐ Gastrointestinal | ☐ Suicide attempt or self-harm such as cutting |
| ☐ Genital/urinary | ☐ Current Physical Activity Restrictions |
| ☐ Genetic or congenital disorder | |



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Student Last Name: _____ First Name: _____ Grade: _____

My student has permission to use the following non-prescription medications (select ALL that apply)

Any item left blank will not be administered

- | | | |
|--|---|--|
| ☐ Aloe Vera | ☐ Bactine Antiseptic | ☐ Saline Eye Wash/Contact |
| ☐ Antibiotic Ointment | ☐ Lip Balm (individual packet) | ☐ Lens Solution |
| ☐ Anti-itch Gel/Cream | ☐ Orajel | ☐ Sting-Kill |

Screening Disclosure

I understand health screenings (including vision, hearing, height, weight, blood pressure, oral, and BMI) may be done by school health personnel unless I provide the school health office with written notification requesting exclusion from these screenings.

Medication and Emergency Care Authorization

NOTE- Over-the-counter (OTCs) medications **will not be provided at school at this time without a written order from your medical provider, in addition to the unopened medication being provided by the parent/guardian. Request the Medication Authorization Form from the School Nurse for any medications to be administered at school. In the event of a life-threatening, anaphylactic emergency, the administration of stock auto-injector epinephrine may be used if deemed necessary by the School Nurse. Students are not allowed to carry medications unless authorized by regulations or School Nurse approved medical orders.*

If for any reason, a Parent or Guardian cannot be reached, I understand that appropriate transport and medical care of my child will be arranged to ANY appropriate medical care provider, hospital, or medical facility. Nothing In this section shall be construed to impose liability on any school official or school employee, who in good faith, attempts to comply with this section. It is understood that I will be financially responsible for all emergency care. I understand information on this card will be shared with appropriate personnel on an as-needed basis only.

CONTACTS AUTHORIZED FOR EMERGENCIES (MUST BE OLDER THAN 18 YEARS OF AGE)

Parent/Guardian Name #1: _____ Phone(s): _____

Relationship to Student: _____

Parent/Guardian Name #2: _____ Phone(s): _____

Relationship to Student: _____

Emergency Contact Name: _____ Phone(s): _____

Relationship to Student: _____

Signature of Parent/Guardian _____ Date _____

****Parents/guardians, please remember to contact the school office with changes in your student's information such as phone numbers, addresses, and authorized contacts.****